STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235281	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearstream Rehabilitation and Nursing Center	240 E North St Hastings, MI 49058

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to immediately notify the resident's physician of a change in condition in 1 of 4 residents (Resident #103) reviewed for physician notification, resulting in lack of assessment and physician involvement following two unwitnessed falls, with known head trauma. Findings include: Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included dementia. Review of Resident #103's Nurse's Note dated 4/13/24 at 11:15 PM written by Registered Nurse (RN) N revealed, Resident kneeling at side of bed with forehead touching the floor .Resident does not know what happened. VSS (vital signs stable) and denies pain. Resident placed in wheelchair and brought to common area to observe. Hospice notified, (Director of Nursing (DON) B) notified and Guardian notified. At 11:45 PM while charting above note, this nurse heard sound behind and turned to find same resident on the floor. Raised bump at right temple with purple center. No open abrasion. Placed in recliner in common area to continue to watch. In an interview on 6/25/24 at 2:06 PM, RN N reported that a physician should be notified of a fall if the resident sustained an injury, and/or hits their head. RN N reported that she does not always notify a physician when a resident falls. In an interview on 6/25/24 at 6:00 PM, Nursing Home Administrator (NHA) A reported that the facility did not notify the physician of Resident #103's fall on 4/13/24 because Resident #103 was a hospice resident. NHA A reported that the facility nurse notified the hospice nurse, and that NHA A would expect that the hospice nurse would communicate with the hospice physician. In an interview on 6/25/24 at 6:00 PM, Regional Nurse Consultant (RNC) II reported that it was the responsibility of the hospice nurse to communicate with the hospice physician regarding Resident #103's fall. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/25/24 at 6:34 PM, Hospice Registered Nurse (HRN) HH reported that Resident #103 had signed onto hospice on 4/13/24 (less than 24 hours prior to the fall) and had an initial admission's assessment on 4/14/24. HRN HH reported that a call had came in on 4/14/24 at 12:04 AM from the facility, reporting that Resident #103 had fallen twice and had a bump on her head. HRN HH reported that a Registered Nurse (RN) visit was offered to examine Resident #103, but that the facility declined the offer. HRN HH reported that the hospice company would expect the facility nurse to contact the resident's physician to notify them of the fall and provide further recommendations. HRN HH reported that the hospice nurse would notify the hospice physician, only if a physical examination was performed by the hospice nurse. Review of Resident #103's Provider Follow Up Visit Note dated 4/15/24 at 1:00 AM indicated that the resident was seen to follow-up from a UTI (urinary tract infection). There was no mention of the resident's fall. The note indicated that the nursing staff had no concerns. The physical exam indicated generalized weakness and full range of motion (ROM).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #'s MI00144035 and MI00144038. Based on observation, interview, and record review the facility failed to protect the resident's right to be free from resident to resident physical abuse in 2 of 4 residents (Resident #105 and #104) reviewed for abuse, resulting in Resident #104 being physically abuse by Resident #105 twice in an 8 day period. Findings include: Review of a Facility Reported Incident dated 4/1/24 at 1:30 PM revealed, .Multiple staff witnessed (Resident #105) have her hands on (Resident #104's) shoulders. (Resident #105) was walking past (Resident #104) and stopped behind her, then placed her hands on (Resident #104's) shoulders .Investigation: .When asked why (Resident #105) touched (Resident #104) she stated, because she wanted (Resident #104) to know that people were watching her. (Resident #105) stated that she came behind (Resident #104) and placed her hands on (Resident #104's) shoulders and gave a little squeeze .When asked why (Resident #105) did this, (Resident #105) said, She was saying things about me, and I did not like it .Encourage after lunch activity participation for both residents. When residents are in common areas, the residents will be encouraged to keep separate from each other to avoid further incident . Review of a Facility Reported Incident dated 4/9/24 at 8:50 AM revealed, .(RN FF) reports (Resident #105) took a hold of (Resident #104's) and bent them back. (Resident #105) reports (Resident #104) threw another resident's cookies on the floor and that resident wasn't there to defend her cookies. So, she stated she had to address it .Redness noted on (Resident #104's) finger area immediately following incident .Investigation: . An X-Ray was ordered for (Resident #104) .of the Right hand. The impression was, No recent fracture or dislocation . (Resident #105) was transferred to (name omitted) NeuroPsych Hospital for evaluation & Treatment . Resident #105 Review of an Admission Record revealed Resident #105 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and psychosis. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 3/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #105 was cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #105's Care Plan revealed, .FOCUS: Resident has potential to be physically aggressive r/t (related to) anger, dementia, depression, history of harm to others, poor impulse control. Date Initiated 1/5/24 .INTERVENTIONS: .Assess the impact of powerlessness on the resident's physical condition .Give the resident control over her environment. Encourage the resident to furnish the environment with those things that she finds comforting. Date initiated: 4/1/24. Revision on: 4/16/24 .When the resident becomes agitated: Intervene before agitation escalate; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. Date initiated: 1/5/24 . FOCUS: Resident has potential to be verbally aggressive, and confabulation of events. r/t mental/emotional illness. Date initiated: 1/29/24 .INTERVENTIONS: .Give the resident as many choices as possible about care and activities, Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document .Date initiated: 1/29/24 . During an observation on 6/25/24 at 10:12 AM Resident #105 was awake, lying in her bed, with her door open to the hall. There was no one interacting with the resident, and there was no one from the activity department on the unit. During an observation on 6/25/24 at 4:34 PM Resident #105 was awake, lying in her bed, with the door open. There was no one interacting with the resident, and there was no one from the activity department on the unit. In an interview on 6/25/24 at 4:58 PM, Director of Nursing (DON) B reported that following the recent resident to resident incidents, the facility had tried to keep Resident #105 busy with activities, and gave her a private room. DON B reported that there was supposed to be someone from activities present on the locked dementia unit for 6 hours a day. DON B reported that Resident #105 had a previous incident in November 2023, and at that time an intervention was put in place to have an alarm in the room, so that staff were made aware when the Resident #105 was out of bed, and could provide supervision. DON B reported that the intervention was still in place during the incidents that occurred in April 2024, and staff should have been alerted to her being out of her room. In an interview on 6/25/24 at 5:16 PM, Social Worker (SW) P reported that the interventions in place for Resident #105's behaviors, are to keep activities staff on the locked dementia unit, talking to her, one to one activities with her, something to keep her engaged and not bored. In an interview on 6/25/24 at 5:21, Activities Director (AD) C reported that activity staff work on the locked dementia unit daily from 1:30-2:30 PM doing one on one activities, and also try to bring those residents to regular activities off of the locked unit. AD C reported that there is staff almost everyday on that unit, but that the weekends are rough because there is only 1 activity aide working for the entire facility from 8:00 AM to 4:30 PM. AD C reported that for Resident #105, they mainly walk with her. Resident #104 Review of an Admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia. Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 3/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #104 was cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #104's Care Plan revealed, .FOCUS: Resident is/has potential to be physically aggressive when she feels like someone is invading her space r/t dementia with behavioral disturbances. Date initiated: 6/18/24 .INTERVENTIONS: Resident's triggers for physical aggression are someone invading her space or the space of her friends. The resident's behaviors are de-escalated by removing her from the situation or removing the invader, Give the resident as many choices as possible .Administer medications . Administer antipsychotic medications .Date initiated: 6/18/24 . There was no information regarding the resident's tendencies for making verbally inappropriate comments. In an interview on 6/25/24 at 11:57 AM RN O reported that Resident #104 is known to make rude comments to other residents, and was almost always sitting in the common area. RN O reported that the facility needs more activities, and an extra person to help supervise, and redirect residents when they are bored and/or become agitated. RN O reported that the only dementia training they have had was the monthly computer tests, and that there had been no focused dementia training for staff that work in the locked unit. In an interview on 6/25/24 at 1:59 PM, Director of Nursing (DON) B reported that Resident #104 had no filter and frequently verbalized inappropriate things about other residents. DON B reported that all residents that reside in the locked dementia unit required close supervision and therefore the facility ensures the unit is always full staffed, and if there is a call in, they will pull from another area in the facility. During an observation on 6/25/24 at 4:54 PM in the common area, Resident #104 is sitting in an easy chair, making frequent comments to and about other residents that are walking around the room. Resident #104 became agitated when this surveyor attempts to interview her. Staff were in the area charting in, but there was no one interacting with the residents. In an interview on 6/25/24 at 10:16 AM, CNA F reported that Resident #105 is triggered easily by certain people and loud noises. CNA F reported that Resident #105 and Resident #104 do not get along. CNA F reported that Resident #105 gets very agitated when Resident #104 is talking and lashes out at her. In an interview on 6/25/24 at 11:25, CNA E reported that Resident #105 and Resident #104 argued frequently, and if staff were present, they would redirect the residents. CNA E reported that it was normal for Resident #104 to make rude comments to Resident #105, and for Resident #105 to be abusive. CNA E reported that Resident #105 had injured Resident #104's hand and also tried to choke her. CNA E reported that staff that work in the locked unit do not receive any focused dementia training, and the only training related to dementia that she had received was when it popped up on a computer quiz. CNA E reported that there was rarely staff from activities present in the evening and/or on weekends, but when activities staff were present, there were less issues with behaviors. In an interview on 6/25/24 at 2:15 PM, RN N reported that Resident #105 had always been physically abusive to staff, and had multiple occasions where she had become physically aggressive with other residents. RN N reported that Resident #105 did not get along with Resident #104, and would become agitated very quickly if Resident #104 started talking. RN N reported that Resident #105 had been sent out to inpatient psychiatric services on two occasions, and was usually less agitated for a while after she returned to the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/25/24 at 4:01 PM, RN FF reported that Resident #105 was very physically abusive to staff and residents, and required close supervision at all times when she was out of her room. RN FF reported that on 4/1/24 Resident #105 grabbed Resident #104 and was bending her fingers back, everyone was busy passing breakfast trays and not able to get there in time. RN FF reported that she, herself did not even know Resident #105 was out of her room until Resident #104 started yelling. RN FF reported that Resident #104 was complaining of pain in her hand, and an x-ray was ordered. RN FF reported that Resident #105 also had incident on 4/9/24 where she was trying to choke Resident #104. Review of Resident #104's X-Ray dated 4/9/24 revealed, .Findings Right hand: Examination reveals mild soft tissue swelling .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to recognize and report an injury of unknown origin for 1 resident (Resident #103) of 4 residents, reviewed for reporting, resulting in the lack of reporting and the potential for a delay in the investigation. Findings include: Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included dementia. Review of Resident #103's Hospice Phone Communication Records dated 4/15/24 revealed, .facility stating patient woke up this morning complaining of right hip pain and they want to get an x-ray. I asked if they had some pain medication to treat the pain and she does so she will give the pain medication. I asked if she has fallen or injured her hip in any way and the CG (caregiver) is not aware of any injury. So at this time we will not order an X-ray but treat the pain and will let RNCM (registered nurse case manager) know of the request. Review of Resident #103's Progress Note dated 4/15/24 at 3:33 PM revealed, .Received order for X-ray of right leg and hip. medical diagnostic notified. Review of Resident #103's Right hip X-Ray revealed, .Examination date: 4/15/24 at 12:40 PM, Reported date: 4/15/24 at 3:27 PM .Impression Right Hip: Impacted intertrochanteric (hip) fracture with varus (towards the body's midline) deformity . This document indicated that the results were reported on 4/15/24. Review of Resident #103's Progress Note dated 4/16/24 at 5:14 PM written by Director of Nursing (DON) B revealed, X-ray of right hip .was ordered on 4/15/24; Results indicated: .Impacted intertrochanteric fracture with varus deformity .Care Plan has been reviewed and updated. There was no indication of the cause for the fracture, and no indication of when the results of the X-ray were received. In an interview on 6/25/24 at 1:41 PM, DON B reported that Resident #103's right hip fracture was not reported to the state as an injury of unknown origin, because the facility had traced it back to her fall on 4/13/24. DON B reported that initially Resident #103 did not have any complaints of pain, and there was no concern with range of motion. DON B reported that a post fall assessment had not been documented in Resident #103's record. DON B reported that on 4/15/24 the resident woke up complaining of right leg pain and was not able to bear weight, and that was when an X-ray was obtained, which ultimately revealed the hip fracture. DON B reported that he was not able to find the documentation to show when the IDT (interdisciplinary team) determined that the hip fracture was a result of Resident #103's falls. In an interview on 6/25/24 at 6:00 PM, Nursing Home Administrator (NHA) A reported that Resident #103's fall and hip fracture were discussed and documented on the incident report from her fall. NHA A reported that the right hip fracture was determined to be the result of the fall because Resident #103 had fallen on the right side of her body. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's Incident Report dated 4/13/24 at 11:35 PM and completed by Registered Nurse (RN) N revealed, .Resident had fall getting out of wheelchair and landed on her right side .Resident was assisted up and placed in wheelchair and then into recliner in common room. Has hematoma (swollen bruise) on right temple .Resident stood without any indications of pain or discomfort . The following entries were made by DON B under the NOTES section on the incident report: On 4/18/24: IDT met to review this residents fall. New intervention will be to have anti roll backs installed onto her chair . On 4/19/24: IDT reviewed recent falls .Resident assisted up .Had no display of injury or pain during transfers. Resident had no documented changes in locomotion, movement or change in pain levels on 4/14/24. Resident was evaluated on 4/15/24 due to recent hospital visit and dx (diagnosis) of UTI . On 4/19/24: On 4/15/24 at 7:55 AM, nurse noted pain in the right hip when bearing weight. Hospice was notified. RN from hospice visited resident at 11:51 AM with findings of pain . X-ray ordered at 3:33 PM as resident continued to have difficulty walking. Results of X-ray received 4/16/24 with findings of right impacted intertrochanteric fracture with varus deformity .Fracture is being correlated to the recent falls as a latent injury . The report indicated that that facility was aware of Resident #103's right hip fracture on 4/16/24, and then on 4/19/24 (3 days later) made a determination that the hip fracture was related to Resident #103's fall on 4/13/24. In an interview on 6/25/24 at 2:06 PM, RN N reported that following Resident #103's fall there was no indication that she had broken her hip and stated, .(Resident #103) had no pain and full range of motion . Review of Resident #103's Nurse's Note dated 4/13/24 at 11:15 PM revealed, Resident kneeling at side of bed with forehead touching the floor .Resident does not know what happened. VSS (vital signs stable) and denies pain. Resident placed in wheelchair and brought to common area to observe. Hospice notified, DON notified and Guardian notified. At 11:45 PM while charting above note, this nurse heard sound behind and turned to find same resident on the floor. Raised bump at right temple with purple center. No open abrasion. Placed in recliner in common area to continue to watch. Review of Resident #103's Hospice Phone Communication Records dated 4/14/24 at 12:18 AM revealed, Received call from (RN N) reporting (Resident #103) has fallen XS2 (twice) in last 5 minutes. First time in her room on her knees no injury, was in her wheelchair out in common area and fell and has small knot to right side of head. vital signs wnl (within normal limits). (Resident #103) denies pain. This RN offered visit, visit declined by (RN N). This RN instructed a follow up visit for admission is already on schedule for day shift and to call (hospice) with any changes or concerns. (RN N) verbalized understanding and is in agreement with POC (plan of care). Review of Resident #103's Post Fall Neurological Check Record dated 4/13/24 at 11:15 PM through 4/17/24 at 8:45 PM indicated no abnormalities and/or changes with range of motion (ROM). Review of Resident #103's Hospice Nurse Visit Records dated 4/14/24 at 2:43 PM revealed, .Patient was lying in recliner chair when hospice nurse arrived. Caregiver states patient had 2 falls last night. One fall resulted in bruising to right forehead. Patient slept through nurse visit . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's Provider Follow Up Visit Note dated 4/15/24 at 1:00 AM indicated that the resident was seen to follow-up from a UTI (urinary tract infection). There was no mention of the resident's fall. The note indicated that the nursing staff had no concerns. The physical exam indicated generalized weakness and full range of motion (ROM). Review of Resident #103's Provider Visit Note dated 4/19/24 at 1:00 AM revealed, .Chief Complaint/Nature of Presenting Problem: hip fracture/agitation/UTI .Of note she also has had a right hip fracture . There was no mention of a fall in the note.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41982 This citation pertains to intake #MI00143822. Based on interview and record review, the facility failed to use a sit-to-stand lift (a medical device used to assist individuals in transitioning from a seated to a standing position), as recommended by therapy and per care plan, during a transfer from the resident's bed to wheelchair in 1 (Resident #100) of 3 residents reviewed for safety, resulting in the resident sustaining a laceration requiring sutures. Findings include: Review of an Admission Record revealed Resident #100 was a female, originally admitted to the facility 3/6/24, with pertinent diagnoses which included: muscle weakness (generalized), and cognitive communication deficit. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 3/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #100 was severely cognitively impaired. Review of a General Progress Note dated 3/11/24 at 7:38 PM revealed, Note Text: CNA (certified nurse aide) reported to writer that pt (patient) had sustained an injury to the right leg. CNA was transferring pt from bed to chair and pt said ow after CNA placed pt into w/c (wheelchair) and noticed injury notified charge nurse. Writer assessed wound to RLL (right lower leg) right of shin and was foundto (sic) be a laceration. d/t (due to) cognitive decline pt was not able to described (sic) what happened. (ambulance company name omitted) was notified and sent to (hospital name omitted) ER (emergency room) for evaluation . Review of a Physician's Order for Resident #100 revealed, Send to ER (emergency room) for evaluation of RLE (right lower extremity) d/t (due to) laceration to RLE Verbal .3/11/24 Review of Resident #100's Care Plan in place at the time of the injury revealed a focus of, Resident has limited physical mobility r/t (related to) (r/t was left blank) Date Initiated: 3/7/24 and care planned interventions which included: Resident is PARTIAL WEIGHT BEARING with a date created and initiated on 3/7/24 and Sit to stand for transfers with a date created and initiated on 3/11/24. Review of a General Progress Note dated 3/11/24 at 2:04 PM revealed, Note Text: resident is A&O (alert and oriented) x1 to her self (sic), resident is very weak and difficult to get out of bed, resident will yell out while just laying in her bed c/o (complain of) pain, staff barely touch her and she will yell out. PRN (as needed) Tylenol given so by the time therapy worked with her around 1300 (1:00 PM) resident still yelled out but her daughter was at bedside and kept encouraging resident to keep pushing that she needed to get up and out of bed. therapy has given the okay to use the sit to stand with this resident and to really work on getting her up for meals . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #100's Emergency Department hospital records revealed, .female presenting to the emergency department today .Per nursing home report, EMS (emergency medical services) reports and patient reports there is an unknown mechanism of injury. They initially had said it was an abrasion but upon further investigation they noted it was more of a laceration that needed stitches therefore they sent her in for evaluation .Patient has a 9.9 cm (centimeter) laceration to her right lower extremity laterally. This does have subcutaneous fat exposed throughout laceration. There is no muscle damage. It is very tender to palpation . Laceration Repair .Repair method: Sutures .Number of sutures: 10 (7 simple interrupted, 3 mattress) . In an interview on 6/20/24 at 3:49 PM, Certified Nurse Aide (CNA) W reported she had been the CNA who transferred Resident #100 when she had sustained a laceration to her leg. CNA W reported she had heard Resident #100 yelling that she had to go to the bathroom. CNA W reported she went into Resident #100's room and tried to get her in her wheelchair. CNA W reported she had not checked Resident #100's care plan prior to assisting her. CNA W stated, I just stood her up unfortunately. CNA W reported she had not used a gait belt (a safety device used when transferring a patient), nor had she used the sit-to-stand lift during the transfer. CNA W reported during the transfer, she had stood Resident #100 up and twisted her to try to get her (Resident #100) into the wheelchair and Resident #100 said ouch. CNA W reported when she looked down, she saw a massive cut on Resident #100's leg. CNA W reported that after it happened, first the nurse came in to assess the wound and then Director of Nursing (DON) came in to assess the wound. CNA W reported she told both the nurse and the DON that she had transferred Resident #100 without the sit-to stand and that she had not used the gait belt. In an interview on 6/21/24 at 10:47 AM, DON B reported he had been at the facility at the time Resident #100 received the injury during the transfer and had conducted his investigation immediately. DON B reported he had asked CNA W what had happened to which CNA W had reported that she stood Resident #100 up and pivoted her to her wheelchair. DON B confirmed that CNA W had transferred Resident #100 incorrectly in that she should have used the sit-to-stand lift during the transfer but had not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearstream Rehabilitation and Nursing Center	240 E North St Hastings, MI 49058

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview, and record review, the facility failed to ensure complete and accurate documentation of post fall assessments for 1 of 12 residents (Resident #103) reviewed for complete and accurate medical documentation, resulting in the potential for insufficient follow up and lack of necessary interventions. Findings include: Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included dementia. Review of Resident #103's Nurse's Note dated 4/13/24 at 11:15 PM revealed, Resident kneeling at side of bed with forehead touching the floor .Resident does not know what happened. VSS (vital signs stable) and denies pain. Resident placed in wheelchair and brought to common area to observe. Hospice notified, DON notified and Guardian notified. At 11:45 PM while charting above note, this nurse heard sound behind and turned to find same resident on the floor. Raised bump at right temple with purple center. No open abrasion. Placed in recliner in common area to continue to watch. Review of Resident #103's Post Fall Neurological Check Record dated 4/13/24 at 11:15 PM through 4/17/24 at 8:45 PM indicated no abnormalities and/or changes with range of motion (ROM). In an interview on 6/25/24 at 1:41 PM, Director of Nursing (DON) B that a post fall nursing assessment had not been documented in Resident #103's health record. DON B reported that by initiating a post fall assessment in the computer, that in turn would trigger the follow up nursings assessments for several days following a fall. DON B reported that on 4/15/24 the resident woke up complaining of right leg pain and was not able to bear weight, which ultimately revealed the hip fracture, which was traced back to the resident's fall. According to Legal and Ethical Issues in Nursing, 4th Edition, ([NAME], G, 2006), a major responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure, patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete.